



**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Agency for Healthcare Research and Quality**

**Agency Information Collection Activities:**

**Proposed Collection; Comment Request**

**AGENCY:** Agency for Healthcare Research and Quality, HHS.

**ACTION:** Notice.

**SUMMARY:** This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: **“Pilot Test of an Emergency Department Discharge Tool.”** In accordance with the Paperwork Reduction Act of 1995, 44 U.S.C. 3506(c)(2)(A), AHRQ invites the public to comment on this proposed information collection.

This proposed information collection was previously published in the Federal Register on August 27<sup>th</sup>, 2013 and allowed 60 days for public comment. One comment was received. The purpose of this notice is to allow an additional 30 days for public comment.

**DATES:** Comments on this notice must be received by (INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER).

**ADDRESSES:** Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, by email at [doris.lefkowitz@ahrq.hhs.gov](mailto:doris.lefkowitz@ahrq.hhs.gov).

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

**FOR FURTHER INFORMATION CONTACT:** Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427-1477, or by email at [doris.lefkowitz@ahrq.hhs.gov](mailto:doris.lefkowitz@ahrq.hhs.gov).

**SUPPLEMENTARY INFORMATION:**

**Proposed Project**

***Pilot Test of an Emergency Department Discharge Tool***

The research study “Pilot Test of an Emergency Discharge Tool” fully supports AHRQ’s mission. The ultimate aim of this study is to pilot test a discharge tool which has the potential to reduce unnecessary visits to the Emergency Department (ED), reduce healthcare expenditure in the ED, as well as streamline and enhance the quality of care delivered to ED patients.

The ED is an important and frequently used setting of care for a large part of the U.S. population. In 2006, there were nearly 120 million ED visits in the U.S., of which only 15.5 million (14.7%) resulted in admission to the hospital or transfer to another hospital. Thus the majority ED visits result in discharge to home. Patients discharged from the ED face significant risk for adverse outcomes, with between 3-5 patients per 100,000

visits experiencing an unexpected death following discharge from the ED. Additionally, a sizable minority of patients return to the ED frequently. Published studies estimate that 4.5% to 8% of patients revisit the ED 4 or more times per year, accounting for 21% to 28% of all ED visits. Internal data from John Hopkins Hospital, AHRQ's contractor for this pilot test, supports these findings with 7% of their patients accounting for 26% of visits to the Johns Hopkins Hospital ED in 2011.

Patients who revisit the ED contribute to overcrowding, unnecessary delays in care, dissatisfaction, and avoidable patient harm. ED revisits are also an important contributor to rising health care costs, as ED care is estimated to cost two to five times as much as the same treatment delivered by a primary care physician. Thus it is estimated that eliminating revisits and inappropriate use of EDs could reduce health care spending as much as \$32 billion each year. Overall, an effective and efficient ED discharge process would improve the quality of patient care in the ED as well as reduce healthcare costs.

To respond to the challenges faced by our nation's EDs and the patients they serve, AHRQ will develop and pilot test a tool to improve the ED discharge process. More specifically, this project has the following goals:

- 1) Develop and Pilot Test a Prototype ED Discharge Tool in a limited number of settings to assess:
  - (a) The feasibility for use with patients;

- (b) The methodological and resource requirements associated with tool use;
  - (c) The feasibility of measuring outcomes;
  - (d) The costs of implementation and;
  - (e) Preliminary outcomes or impacts of tool use.
- 2) Revise the Tool based on the results from the Pilot Test.

This study is being conducted by AHRQ through its contractor, John Hopkins Hospital, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of healthcare services and with respect to quality measurement and improvement. 42 U.S.C. 299a(a)(1) and (2).

### **Method of Collection**

To achieve these goals the following data collections will be implemented:

- (1) Pilot Test of the Emergency Department Discharge Tool (EDT)** -- The EDT will be pilot tested in the three John Hopkins EDs in Baltimore. The purpose of the EDT is to assist hospitals in identifying patients who excessively use the ED and can be categorized as "frequent ED users," as well as to target interventions to these patients to reduce the risk of further avoidable revisits. A research assistant will screen the medical record of all adult patients for the presence of frequent ED use, the key risk factor for ED discharge failure. Frequent ED use is defined as: (1) 1 or more previous ED visit within the last 72-hours, or (2) 3 or more previous ED visits within

the last 3 months, or (3) 4 or more ED visits within the last 12 months. This definition can be modified to align with the resources of the individual ED.

This tool uses data collected from the record of patients that are flagged as frequent ED users. By asking patients a series of questions about their medical history, the tool also helps to identify individuals with risk factors that have been shown in the literature to predict sub-optimal ED discharges and resulting revisits. These risk factors include being uninsured, lack of a primary care physician, having psychiatric diseases, abusing substances, difficulty caring for oneself, or having trouble comprehending ED discharge instructions .

A User's Guide (EDT User's Guide) is also provided to assist EDs in developing resources to provide interventions recommended by the EDT. No data collection activities will occur from this manual.

**(2) One Month Patient Follow-up Telephone Interview** – After the ED visit, a project research assistant (RA) will have a follow-up telephone interview with all enrolled patients. During the interview, the RA will inquire about the success of the interventions that were given for the patient.

**(3) Three Month Patient Follow-up Telephone Interview** – Patients who are uninsured will receive an additional phone call 3 months after the ED visit to assess whether or not they were able to acquire insurance.

**(4) Implementer Focus Groups --** AHRQ will conduct four sets of focus groups to collect qualitative data about the usability and usefulness of the EDT from four stakeholder groups: three groups of EDT implementers and one group of research assistants. Questions for each of the focus groups will vary based on their differing objectives:

**(a) EDT Implementers Focus Group (non-RA)** – For *non-RA implementers* of the EDT (RNs, case managers, social workers,), the objectives will include exploring: (1) How well it does or does not meet implementer goals of discharge; (2) experiences with rollout and implementation, including resources required for implementation; (3) impressions of the value, strengths and weaknesses of the EDT; and (4) unintended consequences or impacts on other ED operations. The focus groups will consist of 8 implementers. Three focus groups will be conducted, one for each pilot site.

**(b) Research Assistant Focus Group** – The three research assistants who will be implementing the EDT will participate in one focus group in which they discuss: (1) Experiences with implementation (including comparisons in their experiences across the three test sites; (2) possible areas for improvement (3) unintended consequences or impacts on other ED operations.

**(5) Key Informant Interviews** -- AHRQ will conduct semi-structured interviews with no more than twenty-four individuals that can be classified as either ED Directors, patients, or community care providers. These individuals will provide feedback on issues surfaced during the focus groups. This will provide an opportunity to delve more deeply into specific topics of interest. The interview guides are included as for patients, for community care providers, and for ED Directors.

**a) Patient Interviews** – For the *patients*, the objective will be to explore: (1) The barriers they face in obtaining health care; (2) their experiences in the ED in visits prior to, and after, implementation of the EDT (3) their satisfaction with the care they received in the ED and their remaining unmet needs. Fifteen patients will be interviewed individually.

**b) Community Care Providers Interviews** – For the *post-ED care providers*, the objectives are to explore challenges in communication and coordination for patients referred to them by the ED and the degree to which the EDT can address those challenges. Post-ED care provider focus group members will be drawn from Johns Hopkins Community Physicians, East-Baltimore Medical Center (a primary referral site for patients without primary care), and Healthcare for the Homeless, a not-for-profit organization in Baltimore, Maryland that provides health services, education and advocacy to people affected by homelessness. Six community care providers will be interviewed for this section.

**c) ED Directors Interviews** – Interviews from ED Directors will occur to get their opinions of the EDT from their perspectives as the ultimate orchestrators of processes in the emergency room and decision-makers regarding operations

(resources use, staffing). Three ED directors will be interviewed separately for this portion.

**(6) Administrative and Observational Data** – Quantitative outcome measures will come from an extraction of medical record data and direct observations performed by project RAs. Data will be extracted from hospital billing records and Electronic Medical Records (EMRs) and will include frequency of revisits, cost of 72-hour returns, cost of ED visits per 3 months, and the cost of implementing the EDT. To calculate costs of program implementation, RAs will observe the time required by social work, case management, and nursing staff to implement the interventions prescribed in the tool. They will also keep a log of the materials given to the patients as part of the intervention. To evaluate the percentage of patients evaluated for assistance or placement, RAs will observe case managers/social workers during their interaction with the patients. To evaluate the percentage of follow-up phone calls, the RAs will keep a log of attempts and actual contacts. Since these data collections involve RA observations, or extractions from existing medical records, they pose no burden to the hospital or public and therefore are not included in the burden estimates in Exhibits 1 and 2 below.

No pre-intervention measures will be collected because this is a feasibility study to evaluate the methodology and feasibility of collection of this data.

### **Estimated Annual Respondent Burden**



Exhibit 1 shows the estimated annualized burden for the respondents' time to participate in this pilot test. A research assistant will use the EMR to screen patients for past frequent ED use. This step does not represent a participant burden. Based upon historical data at our three participating sites, we expect approximately 200 patients per week to qualify as "frequent users" at these sites. Based upon available resources and recruitment, we expect to enroll and use the EDT with approximately 50 of these patients per week at each site to identify their specific risk factors and tailor interventions to their needs. Thus we will have a total of 900 patient participants (50 patients/per week \* 6 weeks \* 3 sites = 900 patients total). It will take about 20 minutes per patient to collect the data associated with the EDT. The one-month patient follow-up will be conducted with all 900 patients and will take 10 minutes to complete. The 3-month patient follow-up will be conducted with those patients identified as being uninsured and is estimated to take 5 minutes to complete.

Four focus groups will take place among RAs and non-RA EDT implementers. The first focus group will consist of three RAs who implemented the discharge tool. The other three separate focus groups will exclude RAs and include eight other ED personnel that implemented the discharge tool. The total annualized burden for these focus groups is estimated to be 54 hours.

As a follow-up to the focus groups, in-depth interviews will also be conducted with members from different stakeholder groups. Between 12 and 16 patients will be

interviewed as well as three ED directors and six community healthcare providers. The interviews will be conducted in person and require one hour to complete. The total annualized burden for these interviews is estimated to be 30 hours.

Exhibit 2 shows the annualized cost burden associated with the respondents' time to participate in the pilot test. The total annualized cost burden is estimated to be \$13,262.

**Exhibit 1. Estimated annualized burden hours**

| Form Name  | Number of respondents | Number of responses per respondent | Hours per response | Total burden hours |
|--|-----------------------|------------------------------------|--------------------|--------------------|
| <b>Pilot Test of the Emergency Department Discharge Tool (EDT)</b> |                       |                                    |                    |                    |
| EDT  | 900                   | 1                                  | 20/60              | 300                |
| One Month Patient Follow-up  | 900                   | 1                                  | 10/60              | 150                |
| Three Month Patient Follow-up                                      | 180                   | 1                                  | 5/60               | 15                 |
| <b>Implementer Focus Groups</b>                                    |                       |                                    |                    |                    |
| RA Focus Group   | 3                     | 1                                  | 2                  | 6                  |
| EDT Implementer (non-RA) #1 Focus Group                            | 8                     | 1                                  | 2                  | 16                 |
| EDT Implementer (non-RA) #2 Focus Group                            | 8                     | 1                                  | 2                  | 16                 |
| EDT Implementer (non-RA) #3 Focus Group                            | 8                     | 1                                  | 2                  | 16                 |
| <b>Key Informant Interviews</b>                                    |                       |                                    |                    |                    |
| Community Healthcare Provider Interview                            | 6                     | 1                                  | 2                  | 12                 |
| Patient Interview  | 15                    | 1                                  | 1                  | 15                 |
| ED Director Interview  | 3                     | 1                                  | 1                  | 3                  |
| <b>Total</b>   | 2,031                 | NA                                 | NA                 | 549                |

**Exhibit 2. Estimated annualized cost burden**

| Form Name | Number of respondents | Total burden hours | Average hourly wage rate* | Total cost burden |
|-----------|-----------------------|--------------------|---------------------------|-------------------|
|-----------|-----------------------|--------------------|---------------------------|-------------------|

| <b>Pilot Test of the Emergency Department Discharge Tool (EDT)</b> |       |     |                      |          |
|--|-------|-----|----------------------|----------|
| EDT  | 900   | 300 | \$22.01 <sup>a</sup> | \$6,603  |
| One Month Patient Follow-up  | 900   | 150 | \$22.01 <sup>a</sup> | \$3,302  |
| Three Month Patient Follow-up                                      | 180   | 15  | \$22.01 <sup>a</sup> | \$330    |
| <b>Implementer Focus Groups</b>                                    |       |     |                      |          |
| RA Focus Group   | 3     | 6   | \$17.86 <sup>d</sup> | \$107    |
| EDT Implementer (non-RA) #1 Focus Group                            | 8     | 16  | \$27.42 <sup>b</sup> | \$439    |
| EDT Implementer (non-RA) #2 Focus Group                            | 8     | 16  | \$27.2b              | \$439    |
| EDT Implementer (non-RA) #3 Focus Group                            | 8     | 16  | \$27.42b             | \$439    |
| <b>Key Informant Interviews</b>                                    |       |     |                      |          |
| Community Healthcare Provider Focus Group                          | 6     | 12  | \$45.36 <sup>c</sup> | \$544    |
| Patient Interview  | 15    | 15  | \$22.01 <sup>a</sup> | \$330    |
| ED Director Interview  | 3     | 3   | \$97.30 <sup>e</sup> | \$292    |
| <b>Total</b>   | 2,031 | 549 | NA                   | \$12,825 |

\* National Compensation Survey: Occupational wages in the United States May 2012, "U.S. Department of Labor, Bureau of Labor Statistics."

a – based on the mean wages for All Occupations (00-0000)

b - salary based upon average of: 2 nurses (29-1141), 2 case managers (29-1141), 2 social workers (21-1022) , and 2 research assistants (19-4061)

c - salary based upon average of: 2 physicians (29-1060), 2 nurses (29-1141), 2 case managers (29-1141), 2 social workers (21-1022).

d – based on mean hourly wage of: Social Science Research Assistants (19-4061)

e – based on mean annual wage of: Physicians and Surgeons (29-1060)

### **Request for Comments**

In accordance with the above-cited Paperwork Reduction Act legislation, comments on

AHRQ's information collection are requested with regard to any of the following: (a)

Whether the proposed collection of information is necessary for the proper performance of AHRQ health care research, quality improvement and information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s)

of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: January 16, 2014.

Richard Kronick,  
AHRQ Director.

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